# Graduation Date Verification Form

**ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.**

FORM TO BE COMPLETED BY THE PROGRAM DIRECTOR OR AN APPROPRIATE DESIGNEE
(The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Student's Last Name: _____ First Name: _____ Middle Initial: _____

Allied Healthcare Program Enrolled: _____

School Name: _____

School Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Year Entered (Month / Year): _____ Expected Graduation Date (Month / Year): _____

Enrollment Status: ☐ F/T or ☐ P/T # of units currently enrolled: _____

**Current GPA:** _____

Please comment on the student's performance and potential for academic success.

_____

_____

_____

_____

_____

_____

_____

Through our selection process, I have determined that the applicant can speak the following Medi-Cal threshold language(s):

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Farsi
- ☐ Hmong
- ☐ Korean
- ☐ Mandarin
- ☐ Other Chinese
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

Name: (Please Print) _____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____

Attach Business Card Here